South Carolina Department of Disabilities and Special Needs

Authorization for EIBI PDD Waiver Services

TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/

_____
Parent Name / **Phone Number**

Service Authorization Number_____

You are hereby authorized to provide the following service(s) to the recipient named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorizations to this provider for this service(s).

Early Intensive Behavioral Intervention Services:

Annual Assessment (H0031): _____
Plan Implementation (H0032): _____
EIBI Lead Therapy (G0177): _____ units/week
EIBI Line Therapy (H0046): _____ units/week
Start Date: _____

Service Coordinator/Early Interventionist: Name / Address / Phone Number / E-mail **(Please Print)**

_____

_____

_____

_____
Signature of person authorizing services **Date**